UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

MDL No. 1456

C.A. No. 01-CV-12257-PBS

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IN RE: PHARMACEUTICAL INDUSTRY *
AVERAGE WHOLESALE PRICE LITIGATION *
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THIS DOCUMENT RELATES TO ALL ACTIONS *

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VOLUME I

VIDEOTAPED DEPOSITION OF VINCENT D. PLOURDE, a witness called on behalf of Johnson & Johnson, pursuant to the Federal Rules of Civil Procedure, before Jessica L. Williamson, Registered Merit Reporter, Certified Realtime Reporter and Notary Public in and for the Commonwealth of Massachusetts, at the Offices of Robins, Kaplan, Miller & Ciresi L.L.P., 800 Boylston Street, Boston, Massachusetts, on Thursday, April 13, 2006, commencing at 9:35 a.m.

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ALSO PRESENT:

Ralph Scopa, Videographer

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PROCEEDINGS

THE VIDEOGRAPHER: Good morning. We are now recording and on the record. My name is Ralph Scopa. I'm a legal video specialist for G & M Court Reporters, Ltd. Our business address is 42 Chauncy Street, Suite 1A, Boston, Mass. 02111.

Today's date is April 13th, 2006. The time is 9:35. This is the deposition of Vincent D. Plourde in the matter of In Re: Pharmaceutical Industry Average Wholesale Price Litigation, U.S. District Court, District of Massachusetts, Civil Action No. 01-CV-12257-PBS.

This deposition is being taken at Robins, Kaplan, 800 Boylston Street, Boston. The court reporter is Jessica Williamson. Counsel will state their appearances, and the court reporter will administer the oath.

MR. MANGI: Adeel Mangi, Patterson Belknap Webb & Tyler, for Johnson & Johnson on behalf of the track one defendants.

MR. MIZELL: Nicholas Mizell, Shook, Hardy & Bacon, for Aventis Pharmaceuticals.

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MR. SKWARA: Steve Skwara, Blue Cross/Blue Shield of Massachusetts.
MR. COCO: Stephen Coco, Robins, Kaplan, Miller & Ciresi, representing Blue Cross/Blue Shield of Massachusetts.

VINCENT D. PLOURDE,
a witness called on behalf of Johnson & Johnson, having first been duly sworn, was deposed and testifies as follows:

DIRECT EXAMINATION
BY MR. MANGI:
Q. Morning, Mr. Plourde.
A. Good morning.
Q. Have you ever been deposed before?
A. I have.
Q. How many times have you been deposed?
A. Once that I can recall.
Q. When was that deposition?
A. I believe it was September of 2004.
Q. What kind of case was that?

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A. I believe it was the Thomas/Solomon case.
Q. You are currently employed by Blue Cross/Blue Shield of Massachusetts, correct?
A. Correct.
Q. What is your title?
A. Vice president of the provider services division.
Q. How long have you held that position?
A. Since 2002.
Q. Your deposition in the Thomas litigation, was that a one-day deposition?
A. It was.
Q. What's your understanding as to what that litigation was about?
A. It was about some alleged improprieties that were believed to have taken place between Blue plans and limiting information that was accessible to providers.
Q. What sort of improprieties and limiting information are you aware of?
MR. COCO: Objection.
A. I'm sorry, what type of --

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Q. Let me rephrase the question. In terms of the allegations that you've just mentioned --
A. Yeah.
Q. -- what specifically was being alleged in terms of improprieties or ways of limiting information?
A. What was -- what was asked of me?
Q. Or your general understanding of what the case was about.
A. I think it was generally around physicians not knowing how exactly specific edits are applied to claims processing. I think that was the general gist, that there was -- they were unaware of information that was being used to make claim payment decisions.
Q. Anything else that you're aware of that was at issue in that case?
A. There was concern about the kinds of disclosures of information to physicians around those claim edits, and I think there were -- I'm trying to think -- again, just general disclosures of information, were providers aware that there were

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edits applied to claims processing?
Q. Was one of the issues in that case disclosure of the actual rates at which reimbursement is made, fee schedules and such, as opposed to edits that are made to the designated rates?
A. I'm not sure I understand your question.
Q. You're aware that there are fee schedules and base payment for providers that are in fee-for-service --
A. Correct.
Q. -- contracts, right?
A. (No verbal response.)
Q. Was one of the issues in the Thomas litigation whether or not those fee schedules were given to providers?
A. I believe that may have been part of the issue, yes.
Q. Was that an issue that you were questioned on at your deposition?
A. No.
Q. Do you have an understanding as to whether

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or not BC/BS of Massachusetts does provide providers with fee schedules?
A. We do.
Q. Are those fee schedules given to providers on a routine basis?
A. They are.
Q. You mentioned edits that are applied during the claims process. What are you referring to there?
A. What -- they're referred to as claim check edits, edits that review claims to see whether or not certain procedures are incidental to other procedures, whether or not claims have been unbundled so that in -- so that a single procedure appears like multiple procedures were performed.
Q. Anything else?
A. That's basically what those edits are -- yes.
Q. Now, why were you deposed in your position as VP of the provider services division in that case?
A. I was deposed --

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MR. COCO: Objection. Go ahead.
Q. Go ahead.
A. I was deposed for two reasons -- actually, three reasons: A, I was the last person deposed, so I think I was -- since I had a general knowledge of a number of different areas, they wanted me there to answer any follow-up questions or any clarification questions. I was also asked to be there because the people who maintain those claim check edits reported in to my organization, and then thirdly, since I also have accountability for the provider relations and provider communications area, they wanted to again clarify what information -- how we communicate information to physicians today.
Q. That segues us conveniently into your current position, and what are your responsibilities, broadly speaking, as the VP of the provider services division?
A. They are to oversee a large provider service center that we operate that's responsible for handling all telephone and written inquiries handling -- responding to claims that may need to be

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adjusted. Also, I'm responsible for an area that does all physician credentialing activities, performs all credentialing activities.
I'm also responsible for an area that puts the providers up on our provider file and maintains that information. I'm also responsible for an institutional provider audit team that audits hospital records and also have a small e-Health initiatives team that I oversee.
And then lastly, I oversee a small provider support team that is basically accountable for working with providers on the HIPAA requirements, making sure that we're able to implement those appropriately, and the most recent piece of that being the national provider identifier implementation.
Q. Step back for a moment, please, to the Thomas litigation. What is your understanding as to the current status of that case?
A. I'm not sure I can answer that because of client -- attorney/client privilege.
Q. Well, do you have an understanding as to

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whether or not the case is ongoing?
A. It is an ongoing discussion, yes. I don't know the -- I can't tell you the status at this moment.
Q. Okay. Do you know whether the case has been settled or whether it's continuing through the legal process?
A. I do not know whether -- I do not know that, whether it's been settled or continuing through the legal process. As of my last understanding, it was not settled.
Q. Stepping somewhat further back in time, could you please describe your educational background after high school.
A. Okay. I attended the University of Massachusetts at Dartmouth where I received my Bachelor of Science in management, and then I attended the University of Rhode Island where I received my master's in business administration.
Q. When did you receive your bachelor's?
A. I graduated in 1980.
Q. And your master's degree?

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A. I received that at the end of 1981.
Q. Did you go directly from your bachelor's program to the master's program?
A. I did.
Q. After completing your master's program, what did you do next?
A. I started working with Blue Cross/Blue Shield of Massachusetts.
Q. So that was in 1981?
A. 1982.
Q. 1982.
A. Uh-huh.
Q. What position did you start in at BC/BS of Massachusetts?
A. Supervisor of the inpatient claims unit and hospital claims.
Q. Have you been continuously employed at BC/BS of Massachusetts since 1982?
A. I have.
Q. How long were you in your position as supervisor of patient claims and hospital claims -- inpatient claims and hospital claims?

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A. One year.
Q. What were your responsibilities in that position?
A. Oversee a unit that processed inpatient claims.
Q. And by "inpatient claims" you are referring to patients who are admitted to hospitals?
A. Correct.
Q. Was inpatient claims and hospital claims, are they both referring to the same thing?
A. No. Inpatient is a type of claim within a hospital. There were separate departments that dealt with different types of claims.
Q. So the hospital claims component of your job also included hospital outpatient departments?
A. No.
Q. Okay. What sections of hospital claims did that cover other than inpatients?
A. Only inpatient claims.
Q. Okay. What I'm trying to understand is whether inpatient claims and hospital claims suggests two different areas of responsibility or

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whether it's just a redundant phrase.
A. It's a -- inpatient is a component of hospital. There are multiple components of hospital. I was responsible for the inpatient component.
Q. Understood. What was the methodology that BC/BS used in '82/83 to reimburse claims related to inpatient treatment?
A. Back in 1982 I believe it was patient on account factor -- a payment on account factor, rather.
Q. What does that mean, "patient (sic) on account factor"?
A. That we would pay a percentage of charges.
Q. Now, the percent of bill charge methodology, did that apply both to services and to drugs?
A. It applied to every service that was provided on an inpatient claim, that was billed on an inpatient claim, yes.
Q. So it would include, for example, a drug that was administered to an inpatient while they

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were in the hospital?
A. It would.
Q. Was there a standard percentage of the bill charge that was paid, or did it vary from service to service and drug to drug?
A. It varied from department to department and hospital to hospital.
Q. What was the basis for that variation?
A. I have no idea. A financial area in the company would calculate what the payment factor was. It was negotiated, and that is what was loaded into the system.
Q. And the actual phrase "account factor," is that referring to the percent applied to the bill charge from that account?
A. No. It's our terminology for applying a percentage of charges.
Q. Okay. As the supervisor of these claims, what did you do on a day-to-day basis?
A. Oversee the production of the unit, you know, made sure that, you know, claims inventories were being managed appropriately, looked at claims,

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would suspend for various reasons, made sure that the turnaround time on various suspense reasons were maintained at appropriate levels, supported other department -- other departments within the -- within the department, for example, you know, would loan people to support the data entry area if they needed it, but pretty much so the bulk of our work was really managing suspended claims.

Q. In this time period, 1982/83, was there any electronic or computerized role to the process?

A. Are you -- providers did submit claims electronically. We --

Q. Would --

A. We processed claims on a computer system, so, yes, there were electronic means being used.

Q. Must have been a big computer.

A. Multiple computers.

Q. Was there any manual processing of claims at that time, or was it all done through this computer system?

A. Definitely manual processing of claims as well.

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Q. In what instances would there be manual processing versus claims going through the computer system?

A. Manual processing. Again, we're talking about 24 years ago. My recollection was there were certain claims that could not go through the computer system and be priced systematically, so someone would have to review those claims, request supporting documentation, and arrive at an appropriate price.

Q. Did the fact that the percentage and the bill charges varied from hospital to hospital and sometimes from department to department give rise to any administrative logistical challenges in terms of claims processing?

A. Not necessarily. Not necessarily. They were all codified in the computer system. I mean, obviously if everyone was paid one flat fee, it would be less variation and potential errors, but everything was codified within the system and was processed accordingly.

Q. How many people did you supervise in your

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position as supervisor of inpatient claims?

A. I had probably about 20 people, 18 to 20 people.

Q. And that staff was dedicated to the inpatient claims; is that correct?

A. Correct.

Q. Was that the only group dealing with inpatient claims?

MR. COCO: Objection.

A. I don't recall. My recollection is that there were probably -- based on the structure that was in place at the time, there were probably a few small departments that did some specialized inpatient claims processing, but it certainly represented the majority of claims that were processed.

Q. Now, in addition to your inpatient claims group, how many other groups were there working in the claims processing area at that time?

A. I would guess probably maybe 180 associates.

Q. And how were they divided up? What were

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the departments other than your inpatient claims department?

A. Well, there was an outpatient claims department. There was an approvals unit that would work with the hospitals for new admissions. There were some national units that, again, had some specialized arrangements. There were -- there was a mail area, a microfilm area that retrieved records and archived information, and there was lastly a provider service department that answered hospital-related inquiries.

Q. Was there a department that dealt with the processing of claims from physicians' offices?

A. There was -- there was in the company, not in my department.

Q. The group that dealt with outpatients, I assume you're referring there to hospital outpatient departments?

A. Correct.

Q. Do you know what methodology BC/BS of Massachusetts used in 1982/1983 to reimburse hospital outpatient departments?

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A. I believe that was also payment on account or percentage.
Q. And that applied both to services and to drugs administered to patients?
A. I don't have any specific knowledge. I would presume, but I don't have exact knowledge.
Q. At that time do you know what methodologies were being used to reimburse physicians for services and drugs they administered in their offices?
A. I do not.
Q. The bill charges that -- a percentage of which was reimbursed towards hospitals, do you know how those bill charges were calculated in this time frame?
A. I do not.
Q. What was your next position after supervisor of inpatient claims and hospital claims?
A. It was assistant to the director of Blue Cross claims.
Q. How long did you hold that position?
A. One year.

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Q. Who was the director of Blue Cross claims at that time?
A. Rick Commander.
Q. And what were your responsibilities as assistant director of Blue Cross claims?
A. Basically his staff person maintained inventory reporting for the entire division, chased down -- you know, worked on special projects as assigned, basically helped facilitate information for the director.
Q. Do you recall what sorts of special projects you were assigned within that time period?
A. There was one project where we were selling a new product that had both Blue Cross -- a combined Blue Cross and Blue Shield deductible called ICBM. I couldn't even remember the acronym, but it was ICBM, and it was a new type of benefit design.
In the past Blue Cross had its own deductibles, Blue Shield had its own deductibles. They were two separate companies, and this was a product that had shared deductibles.

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Q. Any other special projects that you recall?
A. No.
Q. Now, did the director of Blue Cross claims have responsibility for the claims processing area, or was it something else?
A. He did. He had responsibility for the claims processing area.
Q. In your role as assistant to the director, did you gain any understanding as to the methodologies that were being used to reimbursement claims from physician offices?
A. I did not.
Q. What was your next position after that?
A. Assistant manager of hospital claims.
Q. How long did you hold that position?
A. For about a year as well.
Q. That takes us up to about 1985?
A. '80 -- yeah, '84, '85, yeah.
Q. In this position were you responsible for all hospital claims or a subset of them?
A. I was responsible for a portion of

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hospital claims.
Q. What portion were you responsible for?
A. I had local claims.
Q. What do you mean by "local claims"?
A. Non-national claims.
Q. Are you referring to claims stemming from hospitals in a particular area?
A. Claims submitted by -- claims submitted by local hospitals for Blue Cross of Massachusetts members.
Q. What other claims were being processed by Blue Cross/Blue Shield of Massachusetts at that time; in other words, there were claims submitted by local hospitals for members which you were responsible for. What other types of claims were they?
A. They would have been claims submitted by subscribers.
Q. Okay. Who were the -- who were subscribers?
A. Blue Cross/Blue Shield members.
Q. Those would be instances where the member

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received treatment, paid the bill and then asked for reimbursement?
A. Correct.
Q. Any other types of claims?
A. I'm trying to think who else would have been -- I think certain DME providers, but, again, it wasn't in my area of expertise, so...
Q. Now, in this time period, 1984/1985, did -- first of all, was the entity called Blue Cross/Blue Shield of Massachusetts at that time?
A. I'm sorry, during what period?
Q. '84/85.
A. They were two separate companies.
Q. Okay. Which company were you working for?
A. Blue Cross.
Q. Did Blue Cross of Massachusetts in 1984/85 have any contracts with hospitals?
A. Yes.
Q. Did those contracts pertain to reimbursement?
A. Yes.
Q. Did the contracts specify particular

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reimbursement rates?
A. Yes.
Q. And the methodology that was specified in these contracts was still a percentage of bill charge?
A. I believe so.
Q. When a claim was -- when a subscriber or a member went to a hospital and received payment -- received treatment, paid the bill, which he later submitted for reimbursement, was that member charged the same amount by the hospital as a hospital would have sought reimbursement from BC/BS if doing so directly?
A. I honestly don't remember.
Q. When a member did seek reimbursement, did those claims come through your department or through another department?
A. It would come through another department called Extended Benefits.
(Discussion off the record.)
Q. The Extended Benefits Department, was that a separate department that you were not responsible

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for?
A. That was.
Q. Do you have an understanding as to what determined whether a member would have to make payment, then seek reimbursement versus the hospital seeking reimbursement directly?
A. For the most part, it would be if a member again was -- didn't identify themselves or was out of -- didn't identify themselves to a hospital as a Blue Cross/Blue Shield member or they were out of state and received services from an out of state hospital, but generally, they were more I think maybe some out-of-state physician claims or in-state drug claims.
Q. Why were in-state drug claims subject to the system where the member made payment then sought reimbursement?
A. That was the system that was in place. All drug claims were subscriber-submitted.
Q. Now, did that apply both to drugs administered to patients in a hospital setting as well as self-administered drugs?

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A. I don't know.
Q. When you say all drug claims were submitted through that process, what were you thinking of? What types of drugs did you have in mind?
A. A member goes to CVS, picks up a prescription, pays for it, then submits receipts after the fact.
Q. If a drug were administered to a patient, if he got an injection or an infusion in a hospital, do you know one way or another whether that claim was submitted by the hospital to BC -- to Blue Cross of Massachusetts versus a patient submitting it?
A. If it was submitted -- if it was performed in a Massachusetts hospital and the member identified themselves as a Blue Cross of Mass. patient, yeah, that would have come through like any other inpatient claim.
Q. And do I recall your testimony correctly that you don't know whether the amount charged to a member as opposed to the amount in a claim submitted to Blue Cross of Massachusetts would be the same?

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A. Yeah, I don't have any recollection of that.
Q. Okay. What was your next position after assistant manager of hospital claims?
A. That was operations manager of hospital claims.
Q. How long did you hold that position?
A. I believe I held that position for a year as well.
Q. How did your responsibilities change when you went from a system manager to operations manager?
A. I assumed responsibility for a second location, so I had employees based in Boston as well as employees based in Braintree.
Q. Did your substantive responsibilities change in any way?
A. Yes. I had significantly more associates.
Q. Did the type of work you were doing change in any way, other than supervising more people in more areas?
A. No. I think the work was the same type of

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work, it was just a larger department.
Q. More responsibility?
A. More responsibility.
Q. What came next after that role?
A. I believe it was director of hospital claims.
Q. And how long did you hold that position?
A. For a couple years.
Q. Now, what did you do in that position?
A. Again, same type of work, just a larger scale of responsibility.
Q. Okay. Do you have an understanding as to how long the percentage of bill charge methodology remained in use in relation to hospital inpatient claims?
MR. COCO: Objection.
A. I do not remember. I know it was in effect for a while before we converted over to different payment methodologies, but I couldn't tell you when one started and one other ended.
Q. What are the other methodologies that you are thinking of?

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A. We did move to a -- I believe we moved to a DRG-based system, which is the system that's in place today.
Q. Okay.
A. And there were some, I think, hospital contracts that had per diem arrangements as well, I believe, but, again, I have very limited knowledge about what those unique hospital arrangements were.
Q. Okay. I understand you don't know when exactly those changes happened. Do you have a general sense in terms of late '80s, early '90s as to when those changes occurred?
A. I don't have a good sense of when those changes took place.
Q. What about hospital outpatient departments; do you know when the methodology used to reimburse hospital outpatient departments changed?
A. Those were primarily payment on account factor till probably maybe three or four years ago, and they still are some combination of payment on account factor arrangements as well as some fee

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schedule arrangements.
Q. Were you involved at all in that transition?
A. I was not.
Q. Now, you were director of hospital claims until sometime around 1988; is that correct?
A. I think it was '80 -- yeah, '88 or -- yeah, '88, I think, yes, yes.
Q. Okay. What was your next position after that?
A. Director of national claims. And that was from 1989 to 1991.
Q. What were your responsibilities in that position?
A. Had many of the same hospital claim accountabilities but now took on some larger national account business. The most significant large account was the FEP program.
Q. FTP?
A. FEP, Federal Employees Program.
Q. What was the Federal Employees Program?
A. It's a Blue Cross/Blue Shield health plan

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that we administer.
Q. Okay. And I take it that provides for treatment for federal employees in return for a rate paid by the government?
A. Correct.
Q. Is that product still in existence?
A. It is.
Q. What's the structure of that product; in other words, is it premium-based, is it cost-based? How is that product set up?
A. I believe it's a cost-based product. We are reimbursed from the FEP OPM office, Office of Personnel Management, and I believe it's basically like an ASC-type product where they pick up all the cost.
Q. What is an ASC-type product?
A. Administrative services contract versus a premium contract where we're bearing all the risk.
Q. So BC/BS of Massachusetts is essentially acting as a claims processor in relation to that program?
A. Correct. And member service functions and

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provider service functions as well.
Q. Now, when a -- under the FEP -- is it called an FEP product? Does the product have a particular name?
A. I'm sure it's got a name. I could not tell you what the name is.
Q. Okay. Well, under the Federal Employees Program the patient goes to a hospital and receives treatment. Do I understand correctly that that hospital will then submit a claim to BC/BS of Massachusetts for reimbursement? That's the first part, right?
A. Correct.
Q. BC/BS will then process the claim and figure out how much should be paid to the hospital, right?
A. Correct.
Q. Will BC/BS of Massachusetts then make the payment to the hospital?
A. Yes.
Q. And BC/BS of Massachusetts will then seek reimbursement for that amount from the federal

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government?
A. Correct.
Q. Now, in addition to recovery of that cost and recovery of the amount that's reimbursed, does BC/BS of Massachusetts also receive a payment in consideration of the service that it's providing?
A. Yes. Yes.
Q. Is that a lump sum, you know, a flat dollar amount?
A. I have no idea.
Q. Okay. Do you know whether or not that amount is related in any way to the dollar sums reimbursed in relation to claims?
A. I would suspect not.
Q. Now, are you familiar with the FSS, the Federal Supply Schedule?
A. I am not.
Q. I take it you're familiar with the VA program?
A. I am -- I know of the VA.
Q. Okay. Are you aware that when the federal government purchases drugs, it does so at particular

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negotiated discounted rates?
MR. COCO: Objection.
A. I am not aware of that.
Q. Okay. Do you know how the amounts that hospitals seek reimbursement for under the FEP are determined?
A. I do not.
Q. Okay. Do you know what methodology is used in generating those claims submitted to the FEP?
A. I do not.
Q. Okay. Who would know -- who is familiar with the FEP program or would know the answers to those questions?
A. I would say Deb Maroney is the person who leads the FEP program.
Q. How long has she been in that position?
A. I would guess a couple of years.
Q. Can individuals who have coverage under the FEP, would they seek treatment at physician offices as well as in hospitals?
A. Absolutely.

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Q. Do you have an understanding as to what methodology is used to reimburse physician offices who submit claims under the FEP?
A. I do not.
Q. And let me ask you specifically in relation to drugs that may be administered to members of the FEP in a physician office or in a hospital setting, do you have any knowledge as to what methodologies are used to reimburse claims in relation to those physician-administered drugs?
A. I do not.
Q. You mentioned that as director of national claims you have responsibility for some national accounts, the hospitals you were dealing with before, and the FEP. Did you have responsibilities for any other programs?
A. I'm trying to think back then. No, I think -- FEP is an example of a national account. There are other national accounts. Stone & Webster was a national account. Any large major national accounts I was responsible for overseeing the claims processing and the account servicing of those as

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well.
Q. What is Stone & Webster?
A. Is a Blue Cross customer.
Q. Is that a company or an employer?
A. It's a company, an engineering firm, I believe.
Q. And they're a customer who uses BC/BS of Massachusetts to provide health insurance for its employees?
A. Correct.
Q. Now, as director of national claims did you have responsibility only for hospital claims or also for physician office claims?
A. 1989, I think at that point -- I think all claims, I think hospital and physician claims at that point.
Q. Now, at that point did you -- had you gained an understanding as to the methodology that BC/BS of Massachusetts used to reimburse physicians for treatment provided to members?
A. Generally speaking, fee for service, yes.
Q. Now, in that time period, 1989 to 1991,

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was fee-for-service the only methodology that was utilized?
A. I do not know.
Q. Do you know whether there were any risk-sharing plans, capitation, withholds, anything of that kind?
A. At that time -- I know I've heard of risk arrangements, I've heard of capitation arrangements. I can't tell you at what point in time they were in effect.
Q. Do you know in this time period, '89 to '91, what methodologies were used to generate the reimbursement amounts paid under the fee- for-service plans?
A. I'm not -- I'm sorry, I don't understand the question.
Q. Okay. Let's break it down. When a physician were to submit a claim in that '89 to '91 time period, one part of the claim could be a claim in relation to a particular service rendered, right?
A. Right.
Q. Do you know -- well, that claim would then

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be processed by reference to the fee specified in relation to that particular service, right?
A. Uh-huh.
Q. Do you know how that fee would be generated or calculated?
A. I do not.
Q. Now, another part of a claim could be a claim in relation to a drug administered to a member in the physician's office, right?
A. Uh-huh.
Q. Okay. And -- you'll need to answer questions verbally so the reporter can take them down, please.
A. Yes.
Q. Thank you. Do you know how the amount calculated for reimbursement in relation to that drug component of a claim would be generated or arrived at?
A. I do not.
Q. Now, as director of national claims what were your responsibilities on a day-to-day basis? What did you do in relation to claims from these

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national accounts?
A. Again, oversee the general operations of all of the areas, monitoring claim inventories, you know, providing account service, back then providing provider service as well, you know, meeting with accounts, addressing their issues or concerns.
Q. Okay. Now, you used the phrase "claims inventories" a few times this morning. What does that mean?
A. Those are the claims that are -- that have not yet been adjudicated.
Q. Okay. So by -- when you refer to managing claim inventories, are you referring to generally ensuring that claims are processed in a timely way?
A. Correct. Correct. That they're entered into the system in a timely way, that if they do suspend out of the system for review or correction, that they're adjudicated, if there are any claims that need to be manually priced, those are done on a timely basis.
Q. Now, you also mentioned part of your responsibility was addressing account concerns or

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issues. In this time period, '89 to '91, what sorts of account concerns or issues were you dealing with?
A. It was really more focused around service delivery, you know, excuse me, how quickly claim phone calls were answered, how quickly claims were turned around, what were financial accuracy rates on claims processed.
Q. Anything else?
A. Implementation of new programs. Very often an account would want a unique benefit or a new program. We would work with them to understand what it was they wanted us to deliver and try to accommodate them.
Q. Were any of the concerns or issues that you dealt with as director of national accounts in the '89 to '91 time period related to the amount of reimbursement that was being provided by BC/BS of Massachusetts?
A. No.
Q. Okay. Would those -- would any concerns or issues of that kind have been submitted to you, or would they have gone somewhere else in the

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organization?
A. I'm not sure I follow the question.
Q. Let me rephrase it.
A. Please.
Q. Let's say I am a provider in 1990 --
A. Provider or an account?
Q. Well, are you referring -- you're referring -- by "account" you're referring to customers, right?
A. Correct.
Q. Okay. I'm referring to providers as in hospitals or physicians. By the way, when you refer to concerns and issues, you were dealing only with customers?
A. I was dealing with providers as well as customers.
Q. Okay. The concerns that you addressed earlier in terms of calls answered, turnaround times and so on, were those concerns expressed by accounts or by providers?
A. Mainly by accounts.
Q. Okay. What sort of concerns did you deal

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with from providers?
A. They may call and have issues with -- their biggest issue was -- at the time would be really either claims inventory that they felt claims weren't processing quick enough or that they felt they were being underpaid on a particular claim.
Q. In what circumstances would this concern of underpayment come up?
A. In the normal course of business providers, billing staff would review claims, and if they felt on a particular claim that they should have been reimbursed more, they would either pick up the phone and call or write.
Q. Now, were these generally circumstances where there was a disagreement as to what aspects of service should be counted in a claim or what aspects of a service should be reimbursed, or were these concerns about the amount specified in reimbursement for a particular service?
MR. COCO: Objection.
A. It was more the former.
Q. Okay. Do you recall --

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A. You know, they would be under the impression that we paid the claim at an incorrect level, a claim line was miscalculated or not applied or that type of thing.

Q. Do you recall dealing with any instances involving the latter situation where the concern was about the amount specified in reimbursement for a particular service or drug?

A. No, I didn't deal with any hospital contracting or physician contracting issues.

Q. So getting back now to the question I asked you earlier, if a provider had a concern in 1990 about the amount he was being reimbursed for a particular service or drug, would you be the person to bring that to as director of national claims, or would there be another department that had staff to deal with that?

A. There would have been another department in provider contracting that would deal with that compliant.

Q. And who in this time period, 1989 to '91, was in charge of provider contracting, if you

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recall?

A. I honestly don't remember.

Q. Okay. After your role as director of national claims, what was your next position?

A. Medex, the director of the Medex CBU.

Q. Medex CBU?

A. CBU, Client Business Unit.

Q. How long did you hold that position?

A. From, I believe, 1991 to about 1995, I believe.

Q. Now, what was the Medex Client Business Unit?

A. It was the first time that we had put -- first time we had aligned the business by specific customers, so in one shop, in this CBU environment, we had all claims processing related to Medex, all provider servicing related to Medex, all member service relating to Medex, all account issues relating to Medex all housed in one area. So essentially all servicing aspects for products were in this new model.

Q. Was Medex a product or an account?

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A. Medex was a product -- several products, type of products.

Q. What types of products was Medex?

A. Medicare supplemental product.

Q. Now, was -- did Medex include a Medigap product?

A. Medex is our Medigap product.

Q. So if a Medicare patient had Medex coverage, that would take care of their co-insurance obligations, correct?

A. Co-insurance, deductible, correct.

Q. I believe you mentioned earlier that Medex was an umbrella that included several products. Did I understand that correctly, or was it just one product?

A. Oh, Medex was a name for several -- there were several different Medex products, yes.

Q. So there were several different types of Medigap products?

A. Levels of coverage.

Q. Levels of coverage, okay.

Now, as director of the Medex Client

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Business Unit, were you the person in charge of that entire unit, or was there someone above you tasked specifically with the Medex unit?

A. I had a boss I reported to.

Q. Okay. Did your boss have responsibility for areas other than Medex, or was he also or she also focused on Medex?

A. She had responsibilities for Medex and other products as well.

Q. Who was your boss at that time?

A. Eleanor Socholitzky.

MR. COCO: Can you spell that?

THE WITNESS: I might be able to. S-O-C-H-O-L-I-T-Z-K-Y.

Q. Hey, almost got it right.

A. Close.

Q. Do you know what her position was at that time?

A. She was vice president of regulated products.

Q. Now, as director of the Medex Client Business Unit did you acquire an understanding as to

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the methodologies that Medicare was using to reimburse hospitals or physicians for treatment rendered to Medicare beneficiaries?
A. Very generally.
Q. Let's talk about physician offices to begin with. Did you get an understanding as to how Medicare calculated the amounts it would reimburse physicians for services that they provided to Medicare beneficiaries?
A. Not necessarily. What we would do is our responsibility was to pick up the balance so we didn't readjudicate or reevaluate how Medicare processed a claim. We took -- every claim that we got always had either a Medicare remittance attached or it was crossed over from the Medicare processor with that Medicare information in there. So all we basically did was pick up the balance between what the Medicare allowed amount was, what Medicare paid and we picked up the balance.
Q. I understand that that's how the -- that's what the Medex product was structured towards. My question, though, is a little broader. Given that

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you were picking up a portion of the general Medicare charge, did you get an understanding as to how the Medicare charge was calculated?
A. I did not.
Q. Okay. Are you familiar with the term "RBRVS"?
A. I am.
Q. What is RBRVS?
A. I believe it stands for Relative Value-Based Resource System or something like that.
Q. Do you know what RBRVS is used for?
A. It is used for arriving at the value of a claim.
Q. Do you understand that RBRVS is a methodology that is used to calculate the value of claims relating to services?
A. Correct.
Q. Okay. When did you first become familiar with RBRVS?
A. I would have to say maybe 1998 or so.
Q. During the period when you were director of the Medex Client Business Unit you were not

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familiar with RBRVS?
A. May have heard the term, never used it.
Q. During that time period, '91 to '95, did you know how Medicare determined the amount to reimburse physicians for drugs that they administered in their offices?
A. I did not.
Q. At some point subsequently did you gain an understanding as to how Medicare reimbursed for drugs administered in physicians' offices?
A. I did not.
Q. Okay. So as you sit here today, do you have any idea how Medicare currently reimbursed for drugs administered in physicians' offices or how it's done so at any point in the past?
A. I have a general knowledge that they process a percentage off the AWP, but that's the extent of what I could tell you.
Q. During the time period you were the director of the Medex unit, did you have an understanding as to how Medicare calculated amounts it would reimburse hospitals, inpatients or

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outpatients, for services and drugs?
A. Not specifically, no.
Q. What was your next position after your role as director of the Medex Client Business Unit?
A. 1995 through 1998 I was the director of the claims division.
Q. Let me turn back for a moment to the FEP product. At the time that you first gained responsibility for that product when you were director of national claims, was that product already in existence?
A. I believe so. I honestly don't know. I believe so.
Q. And was it something that was launched while you were the director of national claims, that you recall?
A. I don't recall.
Q. Okay. Do you know if that -- that product is still in existence today, correct?
A. A product, an FEP product is still in place today, yes.
Q. Has there been an FEP product in existence

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continuously from 1989 to the present time?
A. I believe there -- I believe there has.
Q. Now, in '95 you became director of the claims division?
A. Correct.
Q. How is this different from your previous role as director of national claims?
A. This was the first time that all claims processing, both Blue Cross and Blue Shield were all under one environment, so we consolidated claims processing units throughout the state, brought them all together, relocated them in Quincy and put them in one organization.
Q. Now, what was the -- can you help me understand the distinction in that time period between the Blue Cross entities and the Blue Shield entities and what was happening that they were coming together?
A. The companies were merged becoming one entity. And prior to -- I couldn't tell you the date that the actual merger happened, but we were no longer Blue Cross of Massachusetts and Blue Shield

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of Massachusetts, but we became one entity.
As we made that transition we were operating on -- each company was operating on its own -- multiple of its own claims processing systems. So as we brought more of those activities together we were not only consolidating locations, but we were also consolidating systems.
Q. Now, prior to the merger do I understand correctly these were independent, unrelated companies?
A. That's my understanding, yes.
Q. Okay. Did the -- did Blue Cross of Massachusetts and Blue Shield of Massachusetts have different methodologies that they used for reimbursing claims prior to the merger?
A. I believe they did.
Q. So when the merger took place, it was not just a matter of merging locations and systems, but the amounts set for reimbursement also had to go through a process of reconciliation and revision, correct?
A. Correct.

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Q. As director of the claims division did you play a role in that merger process, that revision and reconciliation process?
A. I'm trying to think. I think by that time that merger had already happened.
Q. Okay.
A. We were going through a different conversion during 1995. We were converting -- we were wrapping up the conversion to our new computer system, TPS. We started that conversion, I believe, in 1992, and we were completing -- so that all Blue Cross and -- all Blue Cross and Blue Shield claims were all going to be processed on one same -- a single system.
Q. Now, the new system, that is referred to as TPA, did you say?
A. TPS.
Q. TPS. What does that stand for?
A. Total Processing System.
MR. MANGI: Off the record for a second.
(Discussion off the record.)
MR. MANGI: We've be going about an hour.

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Do you want to take a break?
MR. COCO: Yeah, that's fine.
THE VIDEOGRAPHER: The time is 10:37. We're off the record.
(Recess taken.)
THE VIDEOGRAPHER: We're on the record at 10:49.
BY MR. MANGI:
Q. Mr. Plourde, before the break we discussed the couple of different transitions. One was the Blue Cross and Blue Shield organizations and their systems coming together, and then there was this movement to the TPS system. I would like to ask you about those one at a time. When the Blue Cross and Blue Shield companies merged and their different reimbursement rates had to be revised, reconciled and consolidated into one rate, were there any particular problems or challenges that emerged, that you're aware of?
A. None that come to mind. When the areas merged, you know, they basically remained separate components, so let me just elaborate for a moment.

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When we brought pricing files over, it's not like we took the Blue Shield pricing files and necessarily melded them with the Blue Cross pricing files. It's simply a separate table. So whatever Blue Shield provider rates that were in effect before were housed in one part of the system and whatever Blue Cross rates that were in effect were housed in a different part of the system, but it didn't -- there wasn't an activity to take a professional rate and meld it with the Blue Cross system to come up with a new melded rate.

Q. At some point thereafter, after that initial process of bringing all the rates into one system had been complete, did such a process take place of combining them to arrive at one set of payment rates?

A. I would have to say no. I mean, we today still -- it's a -- we paid based on a number of different arrangements. We pay fee-for- service, we pay I'm sure in some select arrangements charges, we pay payment on account factor. So we use all of those different variables. We pay DRG, we pay per

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diem.

Q. There's no -- there's no distinction today between Blue Cross rates and Blue Shield rates in the system, right?

A. There are -- there are -- no, there are inpatient and outpatient payment on account factors --

Q. Right.

A. -- that are employed. And to answer your question, I honestly can't tell you whether or not -- whether or not I would presume that if the same service were rendered in a hospital versus in an outpatient clinic, that those in fact -- I mean, in a physician's office, that those services in fact wouldn't be paid the same rates because they're two different settings.

Q. I didn't quite follow your last -- your last statement.

A. I guess I'm trying to clarify the statement that you made or the question that you asked around, you know, these rates somehow being the same. And what I'm saying is I'm not sure that

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if a particular procedure is performed, if that procedure is performed in a hospital versus that same procedure being performed in a physician's office. What I'm saying is my sense is those rates of reimbursement are not the same. There's different overhead in a hospital setting to render care than there is in a physician's office.

Q. I didn't intend to raise that issue, but it's an interesting issue, so let's talk about it a bit. Do I understand correctly the point you are making is that there are different payment rates for hospitals versus physicians' offices in part due to the fact that they have different overheads?

A. Correct. Correct.

Q. Do you have an understanding as to which setting is more expensive to Blue Cross/Blue Shield of Massachusetts?

A. My --

MR. COCO: Objection.

A. My sense, and it would just be to my sense, that intuitively I would think that the services rendered in a hospital setting would be

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more expensive.

Q. And that would include a hospital outpatient department as opposed to a physician clinic?

A. Correct.

Q. Okay. Now, what is the basis for the intuitive understanding? In other words, what makes you think that?

A. The fact that the hospital has much more overhead. They have a staff of nurses, they have hospital beds, they have all kinds of other fixed costs that a physician practicing in an office does not have. Now, whether that's reflected in a payment rate or it's differentiated through some type of, you know, multiplier, I have no idea.

Q. Now, let's turn back to the issue I was trying to address earlier which pertains to the coming together of Blue Cross and Blue Shield systems. I understand that when the merger first took place there were just the different components housed in the same system. Today, however, as we discussed, they're not separate Blue Cross rates

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versus separate Blue Shield rates, right?
A. I don't know that I can make that statement.
Q. Okay. Throughout the time period you were director of the claims division from '95 to '98 were those separate Blue Cross versus Blue Shield rates in existence?
A. I believe, yes, that those -- there were separate rates.
Q. And do I understand correctly that you just don't know what happened thereafter, whether or not they were brought together or stayed separate?
A. Correct. I have no idea if they've -- how they've been --
Q. Okay.
A. -- combined.
Q. Now let me ask you about the other transition that you mentioned, which is the move to the Total Processing System. What was the system that was in place prior to that?
A. For which organization?
Q. Well, was the Total Processing System --

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when was the Total Processing System implemented?
A. Began in 1992.
Q. And when it began in 1992, had the merger between Blue Cross and Blue Shield taken place yet?
A. I believe it had already started, yes.
Q. What was the system that was in use prior to the Total Processing System at Blue Cross of Massachusetts?
A. We had our own homegrown system.
Q. What was that system called?
A. I believe it was UCS.
Q. What did that stand for?
A. Unified Claim System.
Q. And do you know what system was used prior to 1992 at Blue Shield of Massachusetts?
A. It was an EDS-based system. I don't know the name of the system.
Q. What does EDS stand for?
A. Electronic Data Systems. They're a vendor that we purchased that system from.
Q. Now, in 1992 did -- after the merger both systems were transitioned to the TPS system --

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A. Correct.
Q. -- or Total Processing System?
A. Correct.
Q. What were the reasons for the transition being made?
A. The most simple reason was just to streamline the process and achieve greater economies of scale rather than maintaining two separate -- and when I say "two separate," you know, I'm being kind. I'm sure there were several separate -- the main processing system was UCS, but I'm sure there were half a dozen other minor processing systems. So the goal was to move -- to shut down those many systems and migrate to one core system.
Q. Was there a reason why an entirely new system was used as opposed to the Blue Shield systems being folded into UCS or the Blue Cross systems being folded into EDS?
A. They were totally different systems, incompatible systems. The EDS system didn't have -- at that time didn't have the ability to process inpatient and outpatient, and the UCS system didn't

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process professional claims.
Q. So the move to the TPS system was required entirely as a result of the merger; is that correct?
A. I wouldn't say it was required by the -- it wasn't required by the merger. I think we chose to consolidate operations to, again, gain greater economies of scale, improve productivity, reduce cost.
Q. Okay. Did you play a role in the transition to the TPS system?
A. I did.
Q. Okay. Now, at the time the transition took place you were director of the Medex CBU, correct?
A. I was.
Q. Was the transition complete by the time you became director of the claims division?
A. Yes.
Q. So as director of the Medex CBU, what was your role in relation to the transition to the TPA -- - TPS?
A. TPS. My responsibility was to make sure

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that we were able to successfully migrate off two separate standalone systems that we had that were altogether different than the other systems to this Total Processing System.

Q. By we are you referring to the Medex CBU?

A. I'm sorry?

Q. When you say "ensure successful migration of the two systems we had," is the "we" in that the Medex Client Business Unit?

A. Me and my staff, my staff and I.

Q. I'm trying to understand, though, if you're referring to your staff in the Medex Client Business Unit?

A. Yes, yes, yes.

Q. Okay.

A. It was our task in the Medex Business Unit to migrate off to -- actually, I think it may have been actually three separate standalone systems to this last phase of TPS. So we were the last implementation event to happen.

Q. Okay.

A. And to make sure that all of the claims

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history, excuse me, all the claims history and appropriate information was converted from old systems to new systems.

Q. Were there any particular challenges or problems that emerged in the course of that transition?

A. Just the usual kinds of problems you expect with a conversion. We had to retrain every associate in the department, probably about 250 associates that needed to be completely retrained on an entirely new system. And we needed to do that at the same time that we were processing on the old system. So basically we had to backfill an additional bunch of positions so that we could gradually phase in the processing on the new system and migrate our trained associates from the old system, move them over to the new system.

Q. How long did that entire transition process take?

A. I would guess it would -- it probably took about six months, six or seven months from start to finish.

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Q. Are you referring there to the entire move to the TPS, or are you referring to the Medex Client Business Unit --

A. Just the Medex component.

Q. Okay. Do you know how long the overall transition took?

A. I believe it started in '92 and finished in '95 when we finished. So it was about a three-year transition.

Q. Okay. Now, during the time period when you were director of the claims division, were there any other system changes or migrations that you're aware of?

A. During what -- I'm sorry, which time frame?

Q. When you were director of the claims division from '95 to '98.

A. Were there any other migrations going on? I'm sure there were. None come to mind.

Q. Okay. Now --

A. We've evolved -- I mean, we were continuous -- like any business, continually trying

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to evolve the business to get to fewer claim systems. At one time we probably had about 12 different small claim systems. So over time we kept trying to streamline that to get down to one central processing system.

The USC system and the EDS-based system may have been responsible for 80 percent combined of all the claims, but there were probably another 20 percent that were in these other ancillary systems that we needed to migrate over.

Q. So by 1995 had those ancillary systems been incorporated into TPS, or was that an ongoing process when you became director?

A. I'm trying to think. Was there anything else? I honestly can't remember. I honestly can't remember.

Q. Okay.

A. My sense is that most of the conversion work, though, was completed in '95, the big piece. Medex was the last, most complex piece to go in.

Q. Okay. Did Medex go in after the ancillary systems, or was that the last of --

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A. No. It was the last major component to go in. So the other systems would have been migrated over during that time, before TPS -- before Medex, rather.

Q. Was Medex -- prior to that time was Medex a standalone ancillary system, or was it part of --

A. It was -- it was part of three. I think I mentioned earlier there were three separate Medex processing systems.

Q. Okay. Well, were they part of the -- did Blue Cross have the EDS system or the -- Blue Cross had the UCS system, right?

A. Correct.

Q. Were the Medex products part of the UCS system, or were they among the --

A. No.

Q. -- ancillary systems you mentioned?

A. Three ancillary systems.

Q. Now, turning back again to reimbursement for drugs administered in physicians' offices, are you aware that through the '90s or the latter part of the '90s Blue Cross/Blue Shield of Massachusetts

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followed Medicare in the amount it reimbursed physicians for drugs administered in office?

A. I'm not aware of what the precise pricing methodology was in that time frame, no.

Q. Are you aware of a transition that took place in that time frame in Blue Cross/Blue Shield of Massachusetts' reimbursement methodology for drugs administered in physicians' offices from 100 percent of AWP to 95 percent of AWP?

A. I am not aware of that.

Q. Okay. If and when such a transition took place, would you as director of the claims division have been informed about it or played a role in updating systems as a result?

A. No. I mean, people in the -- in our IT organization or staff people several levels below would have taken care of that.

Q. So when it came to changes in reimbursement rates, be it for individual codes or across the board, that would be handled by technical staff?

A. Could be handled by technical staff, yes.

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Q. In 1998 what position did you move to?

A. 1998 I moved to provider enrollment and services. That was from '98 to I believe about 2002.

Q. Was that the role you held immediately prior to your present role?

A. Correct.

Q. And what was your title in that --

A. It was vice president of provider enrollment and services.

Q. What were your responsibilities in that capacity?

A. It was to improve the service levels in a poorly performing area and to consolidate activities that were done in multiple places in the organization and pull those together all in one central location so that basically providing kind of front-to-end accountability for provider servicing. It included things like, again, managing a large call center that handled telephone and written inquiries. It involved moving a credentialing function which reported elsewhere in the company

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into this organization. And it also entailed moving a pro -- the provider call center was moving from another division to our division, but, again --

Q. Anything else?

A. -- the major issue, it was poorly performing.

Q. Now, when you say "it was poorly performing," what were you referring to?

A. The service levels that that area was providing were not where we wanted them to be.

Q. Let's break down the services that we're talking about there.

A. Okay.

Q. One service is the call center?

A. Correct.

Q. Another service is the credentialing division?

A. Credentialing area, yeah.

Q. Were there any other components to that poorly performing service?

A. Yeah, provider enrollment was the last component.